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and as the Personal Representatives of Travis Culver Freeman, Deceased

9
10 **UNITED STATES DISTRICT COURT**
11 **CENTRAL DISTRICT OF CALIFORNIA**

12
13 KIMBERLY FREEMAN, individually
and as the personal representative of
14 TRAVIS CULVER FREEMAN,
deceased; KENT FREEMAN,
15 individually and as the personal
representative of TRAVIS CULVER
16 FREEMAN, deceased,

17 Plaintiffs,

18 v.

19 COUNTY OF LOS ANGELES, LOS
20 ANGELES COUNTY SHERIFF'S
DEPARTMENT, and DOES 1 TO 10,

21 Defendants.
22

Case No. 2:24-cv-1600

**COMPLAINT FOR WRONGFUL
DEATH AND DAMAGES**

DEMAND FOR JURY TRIAL

23
24 **JURISDICTION AND VENUE**

25 1. This case arises under 42 U.S.C. § 1983, the American with Disabilities
26 Act (ADA). Accordingly, federal subject-matter jurisdiction arises under 28 U.S.C.
27 §§ 1331 and 1343. Plaintiff's state-law claims arise from the same case and controversy
28 and are within the Court's supplemental jurisdiction under 28 U.S.C. § 1367.

1 in some manner contributed to the death of Decedent, or otherwise caused the
2 deprivation of Plaintiffs' and Decedent's constitutional rights and other harm.

3 **EXHAUSTION OF ADMINISTRATIVE REMEDIES**

4 9. Plaintiffs timely filed the appropriate administrative claim, which has been
5 denied. This lawsuit is timely.

6 **FACTS**

7 **A. General Allegations re: Policy and Practice**

8 10. Defendants County and LASD, with deliberate indifference, gross
9 negligence, and reckless disregard for the safety, security, and constitutional and
10 statutory rights of Plaintiffs, Decedent, and all persons similarly situated (namely,
11 inmates at the MCJ and their loved ones) maintained, enforced, tolerated, permitted,
12 acquiesced in, and applied policies or practices of, among other things:

13 a. Selecting, retaining, and assigning deputies, custody assistants,
14 medical workers, civilian personnel and civilian volunteers to their jails who
15 exhibit deliberate indifference and reckless disregard for the safety, security and
16 constitutional and statutory rights of detainees, arrestees and inmates such as
17 Decedent;

18 b. Failing to adequately adopt and maintain security measures to
19 protect detainees, arrestees and inmates from unnecessary illness and harm,
20 including but not limited to, the following failures: failure to custody and medical
21 personnel and civilian volunteers to monitor detainees and inmates and
22 immediately respond to medical emergency, or any other predictable scenario
23 where the physical safety of an inmate would be jeopardized; failure to
24 adequately screen detainees and inmates for medical disabilities, mental health
25 disabilities and addiction to narcotics; failure to timely provide emergency
26 medical care to inmates suffering from mental health or substance abuse issues;
27 failure to conduct timely and adequately safety checks, which substantially
28 increases the risk to vulnerable inmates, especially those with medical, mental,

1 and substance abuse issues; failure to install, maintain, use, and regular monitor
2 the audio monitoring equipment of inmate- or sound-actuated audio monitoring
3 system, which is capable of alerting personnel who can then respond
4 immediately to an emergency (in violation of California Building Code Title 24,
5 Section 1231.2.22, which requires audio monitoring capable of alerting personnel
6 who can respond immediately¹);

7 d. Failing to adequately train, supervise, and control custody and
8 medical personnel, civilian employees or volunteers in proper law enforcement
9 and medical practices, including operating a jail facility, which includes
10 conducting adequate and timely inmate safety checks and responding
11 appropriately to emergencies;

12 e. Failing to adequately discipline custody or medical employees
13 involved in misconduct;

14 f. Failing to respond to safety-related complaints by detainees and
15 their family members;

16 g. Condoning and encouraging employees in the belief they can
17 violate the rights of persons such as Decedent and Plaintiffs with impunity, and
18 that such conduct will not adversely affect their opportunities for promotion and
19 other employment benefits.

20 11. Plaintiffs are informed and believe, and on the basis of such information
21 and belief allege, that defendants County and LASD ordered, authorized, acquiesced in,
22 tolerated, or permitted other defendants herein to engage in the unlawful and
23 unconstitutional actions, policies, practices, and customs set forth in the preceding
24 paragraphs. Defendants' conduct as alleged herein constitutes a pattern of
25 constitutional violations based either on a deliberate plan by defendants or on
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28 ¹ See Section 1231.2.22, available at <http://www.bscc.ca.gov/wp-content/uploads/Adult-Title-24-SOUL-2018.pdf>

1 defendants' deliberate indifference, gross negligence, or reckless disregard for the
2 safety, security, and constitutional and statutory rights of Decedent and Plaintiffs.

3 12. The death of Travis Freeman at MCJ does not exist in a vacuum, but
4 rather occurred in the context of the County Defendants' ongoing inability to prevent
5 in-custody deaths of inmates suffering from mental health and substance abuse issues,
6 and a failure to provide timely medical care to prevent such deaths. For instance, in
7 October 2022, an inmate at MCJ was pronounced dead at the scene after a delay in
8 LASD staff discovering and rendering resuscitative efforts. *See* Office of Inspector
9 General County of Los Angeles, "Reform and Oversight Efforts" (February 15, 2023)
10 at 14.² Two months later, in December 2022, an inmate in LASD custody, whose cell
11 appeared to be covered in fecal matter, was discovered unresponsive during a Title 15
12 Safety Check and there was a delay in rendering resuscitative efforts. *Id.* at 15.

13 13. The County and LASD are on notice that inmates suffering from mental
14 health and substance abuse issues fail to receive timely ongoing medical care. On
15 February 27, 2023 (three months before Travis Freeman's death), the American Civil
16 Liberties Union of Southern California filed a motion for an order re: contempt for
17 failure to provide adequate medical and mental health care to people in the Inmate
18 Reception Center at MCJ. *See Rutherford v. Cnty. of Los Angeles*, Case No. 75-cv-4111-
19 DDP (C.D. Cal. Feb. 27, 2023) (Dkt. 375). Los Angeles County Supervisor Kathryn
20 Barger acknowledged entrenched problems at MCJ: "Our incarceration model is
21 antiquated and needs to be replaced with a state-of-the art facility staffed with quality
22 professionals who can provide vital substance abuse and mental health treatment."³

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25 ² Available at <https://assets-us-01.kc-usercontent.com/0234f496-d2b7-00b6-17a4-b43e949b70a2/ec1a908d-b955-41a9-807c-d53447bb21c6/Reform%20and%20Oversight%20Efforts%20-%20Los%20Angeles%20Sheriff%27s%20Department%20-%20October%20to%20December%202022.pdf>

28 ³ Available at <https://www.latimes.com/california/story/2023-02-27/aclu-asks-judge-to-hold-sheriff-supervisors-in-contempt-over-jail-conditions>

1 14. In March 2023, less than two months before Travis Freeman died, three
2 inmates at the MCJ died within a nine-day period. In a *Los Angeles Times* article covering
3 this rolling disaster, an American Civil Liberties Union of Southern California senior
4 staff attorney with the stated, “Because the jails are operating 20% over capacity, we’re
5 going to continue to see people dying...There are just too many people there for
6 correctional health services to provide adequate medical care and treatment.”⁴

7 **B. The Death of Travis Culver Freeman**

8 15. Decedent Travis Culver Freeman struggled with mental illness and self-
9 medicated with alcohol and opiates. By 2023, Mr. Freeman was addicted to fentanyl
10 and alcohol. In May 2023, Mr. Freeman was living in a trailer park in Van Nuys, using
11 drugs daily and in need of a serious intervention and drug treatment.

12 16. On May 18, 2023, Mr. Freeman was arrested on an outstanding warrant
13 by the Los Angeles Police Department and transferred to the Men’s Central Jail of Los
14 Angeles County, which is administered by the LASD. Defendant LASD was put on
15 notice that he had not been medically cleared and treated by the arresting officer. The
16 County Defendants were on notice that Mr. Freeman used 1-3 grams of fentanyl a day,
17 and consumed a fifth of distilled alcohol (750 ml) a day, prior to his arrest.
18 Furthermore, they were on notice that Mr. Freeman had Hepatitis A, a mental health
19 disorder (a diagnosis of bipolar and schizoaffective disorder), a history of psychotropic
20 medications, and had attempted suicide.

21 17. Consequently, Mr. Freeman was initially evaluated and treated for opiate
22 and alcohol withdrawal symptoms. Specifically, Mr. Freeman was prescribed 8 mg of
23 Suboxone for treatment of his opioid use disorder. The County Defendants were on
24 notice that Mr. Freeman had gastrointestinal issues and medical staff prescribed him
25 Loperamide.

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28 ⁴ Available at <https://www.latimes.com/california/story/2023-03-28/three-inmates-died-in-the-los-angeles-county-jails-in-just-over-a-week>

1 18. The County Defendants have inadequate procedures for monitoring
2 inmates who are “kicking” opioid addiction, inadequate procedure for maintaining
3 supervision and ongoing medical care of inmates who have mental health and
4 substance abuse issues.

5 19. For the next twelve days that he was in the County Defendants’ custody,
6 Decedent suffered from easily treatable duodenal ulcers that went completely ignored
7 by Doe defendants on the medical and custody staff at the MCJ. Indeed, after vomiting
8 and being sent to urgent care on May 21, 2023, the County and Doe Defendants failed
9 to provide ongoing medical care for the withdrawals and gastrointestinal issues, and
10 failed to provide basic custodial medical monitoring, despite being put on notice of
11 Decedent’s myriad mental health and substance abuse issues.

12 20. Mr. Freeman was assigned to a four-man cell (Cell B4) in Module 2800 at
13 the MCJ. On May 30, 2023, Mr. Freeman’s cellmates had to call for a “man down” to
14 get medical attention for him. Previous rounds of purported “safety checks” by Doe
15 defendants working as custody staff failed to notice that Mr. Freeman was in grave
16 peril.

17 21. Simply put, Doe defendants failed to notice Mr. Freeman’s grave
18 condition and had to rely on the cellmate’s “man down” cries. Once Doe defendants
19 arrived, they found Mr. Freeman supine on his bunk, pulseless, not breathing, pale, and
20 cool to the touch. Medical staff arrived around thirty minutes later and pronounced
21 Mr. Freeman dead.

22 22. According to the County medical examiner, Martina Kenendy, D.O.,
23 Mr. Freeman’s gastrointestinal tract was filled with blood due to duodenal ulcers. Such
24 a condition is easily treated, produces symptoms over an extended period of time, and
25 does not cause sudden death. Doe defendants on both the medical and custody staff
26 were deliberately indifferent to Mr. Freeman’s medical needs in that they ignored his
27 obvious suffering, symptoms and need for help, and failed to summon emergency
28 medical care in a timely manner.

1 **FIRST CLAIM FOR RELIEF**

2 **Violation of Civil Rights – 42 U.S.C. § 1983**

3 **(Against Individual Defendants, Does 1-10)**

4 27. Plaintiffs Kimberly and Kent Freeman bring this claim for relief in their
5 capacity as the successors in interest and personal representatives of the Decedent. The
6 foregoing claim for relief arose in the Decedent’s favor, and the Decedent would have
7 been the plaintiff with respect to this claim for relief had he lived.

8 28. The individual and Doe defendants, while acting under color of law,
9 deprived the Decedent of his civil rights under the Fourteenth Amendments to the
10 United States Constitution, by their deliberate indifference to his health, welfare and
11 medical needs and by failing to intervene to prevent others from violating Decedent’s
12 rights. Among other things defendants failed to check adequately for signs of life when
13 conducting safety checks on Mr. Freeman’s cell; failed to respond to complaints by
14 Decedent and others, failed to summon emergency medical care in a timely manner and
15 had to rely on inmates to call for help; and failed to provide medical care, despite being
16 on notice that he had ongoing medical, mental and substance abuse challenges.

17 29. The individual and Doe defendants, while acting under color of law,
18 deprived Decedent of his civil rights under the Fourteenth Amendment to the United
19 States Constitution when they made intentional decisions with respect to the conditions
20 under which Travis Freeman was confined. The decisions and conditions, include but
21 are not limited to: not monitoring Decedent’s cell, per Title 15 requirements, despite
22 being put on notice that he faced mental, medical and substance abuse issues; failing to
23 monitor and adequately respond to audio monitoring. All of these actions and/or
24 omissions were objectively unreasonable and deliberately indifferent.

25 30. Despite actual and constructive notice of the substantial risk of severe
26 harm facing Mr. Freeman, including, *inter alia*, withdrawal from fentanyl, mental health
27 issues (including a bipolar diagnosis and an attempted suicide), and gastrointestinal
28 issues and need for treatment of his ulcers, the individual and Doe defendants did not

1 take reasonable available measures to abate the risk of injury or death to Mr. Freeman,
2 even though reasonable officers in the circumstances would have appreciated the high
3 degree of risk involved—making the consequences of the Defendants’ conduct
4 obvious. Defendants knew or should have known that Mr. Freeman was vulnerable, in
5 need of timely medical care, adequate medical care and ongoing monitoring.

6 31. The individual and Doe defendants knew or should have known that
7 Mr. Freeman had mental and medical issues that required him to receive timely medical
8 care and adequate safety checks.

9 32. The individual and Doe defendants subjected Decedent to their wrongful
10 conduct, depriving Decedent of rights described herein, knowingly, maliciously, and
11 with conscious and reckless disregard for whether the rights and safety of Mr. Freeman
12 and other helpless inmates would be violated by their acts and omissions.

13 33. As a proximate result of the foregoing wrongful acts by the individual and
14 Doe defendants, and each of them, Mr. Freeman died in his cell from a bleeding ulcer,
15 and thus sustained general damages, including pre-death pain and suffering, and a loss
16 of the enjoyment of life and other damages, in an amount in accordance with proof.

17 34. In doing the foregoing wrongful acts, Defendants, and each of them,
18 acted in reckless and callous disregard for the constitutional rights of Decedent. The
19 wrongful acts, and each of them, were willful, oppressive, fraudulent, and malicious,
20 thus warranting the award of punitive damages in an amount adequate to punish the
21 wrongdoers and deter future misconduct.

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SECOND CLAIM FOR RELIEF
42 U.S.C. § 1983 -- Deprivation of Fourteenth-Amendment Right
To Parent/Child Relationship
(Plaintiffs individually against all Defendants)

35. The aforementioned acts and/or omissions of Defendants and their deliberate indifference to Mr. Freeman’s serious medical needs, health and safety, shocks the conscience, and their failure to train, supervise, and/or take other appropriate measures to prevent the acts and/or omissions that caused the untimely and wrongful death of Mr. Freeman deprived Plaintiffs of their liberty interest in a parent-child relationship in violation of their substantive due-process rights as guaranteed by the Fourteenth Amendment to the United States Constitution.

36. As a direct and proximate result of the aforementioned acts and/or omissions of Defendants, Plaintiffs suffered injuries and damages as alleged herein, including grief and other severe emotional distress over the loss of familial relations with their child and his love, society and companionship.

37. The aforementioned acts and omissions of Defendants were willful, wanton, malicious, and oppressive, thereby justifying an award to Plaintiffs of exemplary and punitive damages against the individual defendants to punish the wrongful conduct alleged herein and to deter such conduct in the future.

THIRD CLAIM FOR RELIEF
42 U.S.C. § 1983–Unconstitutional Custom, Practice, or Policy (*Monell*)
(Against Entity Defendants)

38. The Entity Defendants, the County and LASD, had both actual and constrictive knowledge of the defective policies, practices, and customs alleged above. Despite having knowledge as stated above of the unreasonable risks and dangers posed to inmates, the County Defendants condoned, tolerated, and through actions and inactions ratified such policies. The County Defendants acted with deliberate

1 indifference to both the foreseeable effects and consequences of these policies and to
2 the constitutional rights of Decedent, Plaintiffs, and other individuals similarly situated.

3 39. Furthermore, the policies, practices, and customs implemented,
4 maintained and still tolerated by Entity Defendants were affirmatively linked to and
5 were the moving force behind Mr. Freeman's untimely death.

6 40. Plaintiffs bring this claim both individually and as a successor-in-interest
7 to Decedent. Plaintiffs seek survival damages, including for the nature and extent of
8 decedent's injuries, pre-death pain and suffering, emotional distress, and loss of life and
9 enjoyment of life, as well as wrongful death damages under this claim. Plaintiffs have
10 individually been deprived of the life-long love, companionship, comfort, support,
11 society, care, and sustenance of Decedent and will continue to be so deprived for the
12 remainder of their natural lives.

13 **FOURTH CLAIM FOR RELIEF**

14 **42 U.S.C. § 1983 –Inadequate Training (*City of Canton*)**

15 **(Against Entity Defendants)**

16 41. At all times mentioned herein and prior thereto, the Entity Defendants
17 had the obligation to train, instruct, supervise, and discipline their subordinates to
18 assure they respected and did not violate constitutional and statutory rights of inmates
19 such as Mr. Freeman, and to objectively investigate violations of inmates' rights,
20 including, but not limited to the right to be safe and protected from injury in
21 defendants' custody, under the Eighth and Fourteenth Amendments to the United
22 States Constitution.

23 42. On information and belief, the County and Doe Defendants facilitated,
24 permitted, ratified and condoned similar acts of medical indifference and neglect and
25 were deliberately indifferent to the health and safety of the inmates in general and
26 Decedent in particular. These Defendants knew, or should have reasonably known, of
27 this practice, pattern or policy of constitutional violations, and additionally, of the
28 existence of facts and situations which created the potential of unconstitutional acts,

1 and had a duty to instruct, train, supervise and discipline their subordinates to prevent
2 similar acts to other persons, but failed to do so. In particular, the Entity Defendants
3 maintained, enforced, tolerated, ratified, permitted, acquiesced in, and/or applied,
4 among others, the following policies, practices and customs:

5 a. Failing to adequately train, supervise, and control custodians of jail
6 inmates in the proper recognition of situations that pose a threat to inmates with
7 mental health, medical and/or substance abuse issues;

8 b. Failing to adequately train, supervise, and control custodians of jail
9 inmates in properly monitoring, deterring, controlling and responding to medical
10 emergencies faced by inmates;

11 c. Failing to establish policies and procedures that enable
12 identification and monitoring of medically compromised inmates;

13 d. Failing to adequately train, supervise, and control custodians of jail
14 inmates in the proper response to provide and/or summon timely emergency
15 medical care;

16 e. Failing to maintain video monitoring/surveillance of inmate areas,
17 such as cell-blocks and cells to ensure safety of inmates, especially those that
18 might be unable to care for themselves;

19 f. Failing to maintain audio monitoring/surveillance of single cells,
20 double-occupancy cells, dormitories, and dayrooms, with audio monitoring
21 capable of alerting personnel who could respond immediately;

22 g. Failing to train, and failing to ensure, employees to conduct
23 adequate and timely inmate safety checks and follow up medical evaluations; and

24 h. Failure to train employees to adequately screen detainees and
25 inmates for mental health disabilities and/or substance abuse issues related to
26 withdrawal from drugs and alcohol, and to monitor inmates identified with
27 health problems secondary to substance abuse and mental health disabilities.
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1 ensure that the personal and civil rights of persons who are receiving services under
2 their aegis are protected.

3 48. Title III of the ADA provides in pertinent part that “[i]t shall be
4 discriminatory to afford an individual or class of individuals, on the basis of a disability
5 or disabilities of such individual or class, directly, or through contractual licensing, or
6 other arrangements, with a good, service, facility, privilege, advantage, or
7 accommodation that is different or separate from that provided to other individuals.”
8 42 U.S.C. § 12182(b)(1)(A)(iii). Under Title III of the ADA, County is mandated not to
9 discriminate against any qualified individual “on the basis of disability in the full and
10 equal enjoyment of the goods, services, facilities, privileges, advantages or
11 accommodations of any place of public accommodation.” 42 U.S.C. § 12182(a).

12 49. Defendants County and LASD receive federal assistance and funds, and
13 are therefore subject to the Rehabilitation Act, 29 U.S.C. § 794. Defendants County and
14 LASD are within the mandate of the RA that no person with a disability may be
15 excluded from participation in, be denied benefits of, or be subjected to discrimination
16 under any program or activity.” 29 U.S.C. § 794.

17 50. At all material times and as described herein, the Decedent:

18 (a) was an individual with a disability;

19 (b) was otherwise qualified to participate in or receive the benefit of
20 Defendants’ services, programs, or activities, including County and LASD jail
21 services, programs, and activities;

22 (c) was excluded from participation in, and denied the benefits of the County
23 and LASD services, programs or activities, and was otherwise discriminated
24 against by County and LASD; and,

25 (d) such exclusion, denial of benefits or discrimination was by reason of his
26 disability.

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1 51. As described herein, Defendants County and LASD failed to reasonably
2 accommodate the Decedent's mental and emotional disability in the course of jailing
3 him., causing him to suffer greater injury in the process than other detainees or
4 arrestees, culminating in his death.

5 52. The County's and LASD's failures to accommodate the Decedent's
6 disability include but are not limited to:

- 7 (a) causing the violation of the Decedent's rights through the acts and omissions
- 8 identified above;
- 9 (b) failing to follow lawful and appropriate policies, practices, and procedures for
- 10 mentally ill inmates;
- 11 (c) failing to provide the Decedent with timely, competent and appropriate
- 12 hospitalization and supervision in the jail;
- 13 (d) failing to house Decedent in an appropriate unit;
- 14 (e) failing to institute proper medical precautions for the Decedent;
- 15 (f) failing to respond to the medical alert system for inmates who
- 16 predictably and routinely require immediate, urgent and necessary medical aid;
- 17 (g) failing to develop an effective, integrated, comprehensive system for the
- 18 delivery of services to persons with disabilities to ensure that the personal and
- 19 civil rights of persons who are receiving services under its aegis are protected;
- 20 and,
- 21 (h) other failures to provide accommodations as the evidence may show.

22 53. As a direct and proximate result of County's and LASD's violations of the
23 ADA and RA, Plaintiffs and the Decedent sustained injuries and are entitled to
24 damages, penalties, costs and attorneys' fees as set forth herein.

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SIXTH CLAIM FOR RELIEF

**Negligence -- Cal. Civil Code 1714, Cal. Gov't Code § 844.6(d)
(Against All Defendants)**

54. At all material times, each individual Defendant and Does 1-10 owed Decedent the duty to act with due care in the execution and enforcement of any right, law, or legal obligation.

55. The individual Defendants and Does 1-10 herein, agents, servants, and/or employees of County, and within the course and scope of such agency, service, and/or employment, and under color of authority, were negligent in regards to Mr. Freeman's health, safety and welfare, and breached that duty of care. Defendant County is vicariously liable for the acts of its employees pursuant to California Government Code § 815.2.

56. These general duties of reasonable care and due care owed to Decedent by Defendants include but are not limited to specific obligations to provide, or cause to be provided, safe conditions of confinement for Decedent, and to provide, or cause to be provided, protection from death and injury while in LASD custody and vulnerable to withdrawal, completely reliant on LASD jailers and medical staff for the provision of medical care and safety checks.

57. The individual Defendant and Does 1-10, through their acts and omissions, breached each and every duty of care owed to Decedent.

58. As a direct and proximate result of the individual Defendants' and Does 1-10's negligence, Plaintiffs and the Decedent sustained injuries and damages as alleged above.

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SEVENTH CLAIM FOR RELIEF

Failure to Summon Medical Care

Cal. Gov't. Code § 845.6

(Against All Individual Defendants and Does 1-10)

59. While in in the custody and during the shift of the individual Defendants and Does 1-10, Mr. Freeman was forced to endure the lack of medical treatment, the lack of adequate safety checks, the lack of responsive treatment to his ulcers, even as his pain was obvious, and the lack of timely emergency care once he became unconscious.

60. The individual defendants and Doe defendants herein agents, servants, and employees of the County, and within the course and scope of that agency, service, and/or employment, and under color of authority, failed to take reasonable action to timely summons medical care for Mr. Freeman, as attested to by the fact his body was discovered cool to the touch, and despite the fact they should have known that that he was in need of immediate medical care, in violation of Cal. Gov't Code § 845.6, had they conducted timely safety checks, and had they monitored Mr. Freeman after being put on notice that he suffered from significant health issues.

61. Defendant County is vicariously liable for the acts of its employees pursuant to California Government Code § 815.2.

62. Without timely medical treatment, Mr., Freeman died, giving Plaintiffs a claim for wrongful death damages under California law.

NINTH CLAIM FOR RELIEF

Breach of a Mandatory Duty

(Against All Defendants)

63. Plaintiffs allege on information and belief that the individual defendants and Does 1-10 violated mandatory duties including, but not limited to, those set forth in California Code of Regulations Title 24, Section 1231.2.22; California Code of

1 Regulations, Title 15, Section 1027.5, as well as those set forth in the Los Angeles
2 County Sheriff's Department Custody Division Manual 4-11/030.00.

3 64. Plaintiffs allege that had the individual defendants and Does 1-10 not
4 breached their mandatory duties, they would have noticed a gravely ill Mr. Freeman and
5 called for necessary emergency medical care of an easily treatable medical problem,
6 namely, ulcers. Therefore, as a proximate result of the individual defendants and Does
7 1-10 failure to perform their mandatory duties, Mr. Freeman died.

8 65. Without timely medical treatment, Mr., Freeman died, giving Plaintiffs a
9 claim for wrongful death damages under California law.

10 66. Defendant County is directly liable for its agents' and employees breaches
11 of mandatory duties, and is vicariously liable for the acts of its employees pursuant to
12 California Government Code § 815.2.

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PRAYER FOR RELIEF

WHEREFORE, Plaintiffs request relief as follows against each defendant:

- 1. General and Special damages, including individual, survival and wrongful death damages, in an amount according to proof;
- 2. Exemplary and punitive damages against each individual and Doe defendant, but not against the entity defendants, in amounts according to proof;
- 3. Cost of suit, including attorneys’ fees under 42 U.S.C. § 1988 and relevant provisions of state law; and
- 4. Such other relief as may be warranted or as is just and proper.

DATED: February 27, 2024

THE LAW OFFICES OF JOHN BURTON

By: /s/ John Burton
John Burton
Attorney for Plaintiffs

DATED: February 27, 2024

LAW OFFICES OF ERIN DARLING

By: /s/ Erin Darling
Erin Darling
Attorney for Plaintiffs

JURY DEMAND

Plaintiffs demands trial by jury on all issues so triable.

DATED: February 27, 2024

By: /s/ John Burton
John Burton
Attorney for Plaintiffs